

MISSOURI DEPARTMENT OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-007867

STATE FILE NUMBER

AMENDED

FILED MAR 15 1962

Primary Registration District No.

Registrar's No.

2513

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | | Length of stay in 1b 64 years | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 917 N. Newstead | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First CARRIE Middle B. Last CARRION | | | | 4. DATE OF DEATH Month March Day 3, Year 1962 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4/16/28 | 9. AGE (last birthday) 83 | IF UNDER 1 YEAR Months 11 Days 17 Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (City and state or country) Atlanta, Georgia | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13a. FATHER'S NAME Unknown | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE William S. Carrion | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Address Mason Carrion 4418 Elmbank | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Hypertension DUE TO (c) Senility 331X | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from 8:05 AM Sept 1958 to March 3 and last saw her alive on March 2, 1962 Death occurred at Community Hospital on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Haskell M.D. | | | 22b. ADDRESS 1303N Kingshighway | | | 22c. DATE SIGNED 3-5-62 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 3/6/62 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem. | | 23d. LOCATION (City, town, or county) St. Louis County, Mo. | | (State) |
| 24. FUNERAL DIRECTOR Charles J. Gates | | | ADDRESS 4107 Finney | | 25. DATE RECD. BY LOCAL REG. MAR 5 1962 | | |
| REGISTRAR'S SIGNATURE E. Smith M.D. | | | | | | | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Huyton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.